TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
THE CENTER FOR DIAGNOSTIC & MEDICAL SERVICES

Respondent Name
FORT WORTH INDEPENDENT SCHOOL DISTRICT

MFDR Tracking Number
M4-98-8592-02

Carrier's Austin Representative
Box Number 16

MFDR Date Received
July 3, 1997

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "MRI Approved with know precert number since 1st MRI."

Amount in Dispute: $1,315.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that the maojnts reimbursed to the requestor in the amount of $756.00 were fair and reasonable and that they met all statutory requirements of Texas Labor Code Section 413.031"

Response Submitted by: Fort Worth ISD

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 28, 1996	Magnetic Resonance Imaging Procedure Code 73221-TC-22	$1,315.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. Former 28 Texas Administrative Code §134.201 adopts by reference the Texas Workers' Compensation Commission Medical Fee Guideline 1996 effective for professional services provided prior to August 1, 2003.
3. Texas Labor Code Chapter 410 Subchapter B. sets out procedures regarding benefit review conferences.
4. The insurance carrier denied payment for disputed services with the following payment exception codes:
   - E – ENTITLEMENT (NONCOMPENSABLE)
     F – REDUCTION ACCORDING TO FEE GUIDELINES

Issues

1. Are there unresolved issues of compensability, extent of injury, or liability regarding the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with payment exception code E – "ENTITLEMENT (NONCOMPENSABLE)." However, upon reconsideration, the insurance carrier did not maintain this denial reason. Review of the submitted documentation finds that there are no unresolved issues of compensability, extent of injury, or liability regarding the services in dispute. The medical fee issues will therefore be reviewed per applicable Division rules and fee guidelines.
2. This dispute is regarding magnetic resonance imaging services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.201, effective April 1, 1996, 21 *Texas Register* 2361, which adopted by reference the *Texas Workers' Compensation Commission Medical Fee Guideline 1996*, effective for all medical treatments, services, durable medical equipment and pharmaceuticals provided on or after April 1, 1996.

   Per the 1996 Medical Fee Guideline, Radiology/Nuclear Medicine Ground Rules, the technical component maximum allowable reimbursement for the extended service of procedure code 73221 billed with modifier 22 is $756.00. The insurance carrier has paid $756.00. No additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	September 25, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.